

SUMMARY CHAPTER III

PREVENTING UNINTENTIONAL INJURY: KEEPING OUR YOUTH SAFE

Injuries are the primary cause of death for adolescents. Injury deaths are classified as unintentional (such as auto crash fatalities) or intentional (homicide and suicide). Unintentional injuries make up the greatest proportion of deaths among adolescents both nationally and in Tennessee.

TENNESSEE DATA



Unintentional injury remains the leading cause of death for youth and young adults ages 10 to 24 years of age. Unintentional injuries kill about 125 Tennessee youth annually.

- In 2002, over 51% of all deaths of young people ages 10-24 were attributed to unintentional injuries.
- The next highest causes of death were homicide (14%) and suicide (8%).
- The number of adolescent deaths due to injuries has increased over the last decade. From 1999-2002 there were 1,880 deaths. This represents an increase of 69 deaths from 1995-1998 and an increase of 100 deaths since 1991-1994.

BEST PRACTICES



- **Parents** – Parents have a key role in injury prevention. They provide the transportation and the financial and emotional support for sports and recreational activities, and are in control of the car keys and insurance. They provide role modeling with their own behavior and set boundaries with appropriate consequences related to alcohol and drug use, behavior and rules of the road.
- **Schools** – Schools have a responsibility to prevent injuries from occurring at school and school-sponsored events. They can also teach the skills needed to prevent unintentional injuries, violence and suicide in all domains and throughout their lives. They have the means to provide recreation injury prevention information to parents, students and athletic staff.
- **Communities** – Communities can integrate and tailor strategies to meet their unique needs and opportunities for injury prevention. It is important to involve relevant stakeholders in planning and implementation of safety plans to increase commitment and involvement in carrying out solutions. Graduated Drivers' License programs are a clear example of an injury prevention strategy established by policy.

2010 OBJECTIVES

Reduce Alcohol-Related Motor Vehicle Deaths

- By 2010, reduce alcohol-related motor vehicle deaths among adolescents and young adults aged 15-24 to 5 per 100,000 from the 2003 baseline of 6.7 per 100,000.

Reduce Riding with Drinkers

- By 2010, reduce the proportion of high school students that rode, in the last 30



days, with a driver who had been drinking alcohol to 20% from the 2003 baseline of 26.6%.

Increase Seat Belt Use

- By 2010, increase the proportion of high school students who wear a seat belt most or all of the time to 92% from the 2003 baseline of 85.6%.

Reduce Teen Motor Vehicle Deaths

- By 2010, reduce motor vehicle deaths among adolescents aged 15-24 to 37 per 100,000 from the 2001 baseline of 42 per 100,000.

Websites

Alive @ 25: A Survival Course in Traffic Safety, by the National Safety Council
www.aliveat25.com

American Academy of Orthopedic Surgeons
www.orthoinfo.aaos.org

American Academy of Pediatrics
www.aap.org

Brain Injury Association of America
www.biausa.org

Bright Futures, Georgetown University
www.brightfutures.org

Center for Enforcing Underage Drinking Laws
www.udetc.org

Centers for Disease Control and Prevention
www.cdc.gov

Children's Defense Fund
www.childrensdefense.org

Children's Safety Network
www.childrenssafetynetwork.org

David and Lucile Packard Foundation
www.packard.org

Healthy People 2010
www.healthypeople.gov

Mothers Against Drunk Driving (MADD)
www.madd.org

National Adolescent Health Information Center
<http://nahic.ucsf.edu/index.php/about/index/>

National Center for Injury Prevention and Control
www.cdc.gov/ncipc

National Highway Traffic Safety Administration
www.nhtsa.dot.gov

National Institute for Occupational Safety and Health
www.cdc.gov/niosh

National Safety Council
www.nsc.org

Office of Juvenile Justice and Delinquency Prevention
www.ojjdp.ncjrs.org

US Consumer Product Safety Commission
www.cpsc.gov

CHAPTER III

PREVENTING UNINTENTIONAL INJURY: KEEPING OUR YOUTH SAFE

Chapter Preview

This chapter includes a description of:

- Adolescent and young adult mortality rates
- Prevention pays
- Motor vehicle crashes, firearm injuries and sports-related injuries issues
- National and state data
- Health disparities data
- Best practices
- State injury prevention programs
- Healthy People 2010 goals

Injuries are the primary cause of death for adolescents. Health experts classify injury deaths as unintentional (such as auto crash fatalities) or intentional (homicide and suicide). Unintentional injuries make up the greatest proportion of deaths among adolescents both nationally and in Tennessee.

The real tragedy is that most injuries to adolescents, whether unintentional or intentional, are preventable events.

Adolescents often act on impulse, underestimate danger, may not comprehend the consequences of their actions and have less experience coping with potentially hazardous situations. Adolescence is when the brain is creating the “wiring” for perspective and judgment. Thus, opportunities for injury prevention education present themselves in every domain of an adolescent’s life: home, school, community and workplace. Teachable moments exist every time an adolescent learns a new skill – for example, on the athletic field or behind the wheel of a car. Injury prevention strategies can be embedded in a variety of arenas: education, law enforcement, parental modeling and the media, for example.

PREVENTION PAYS

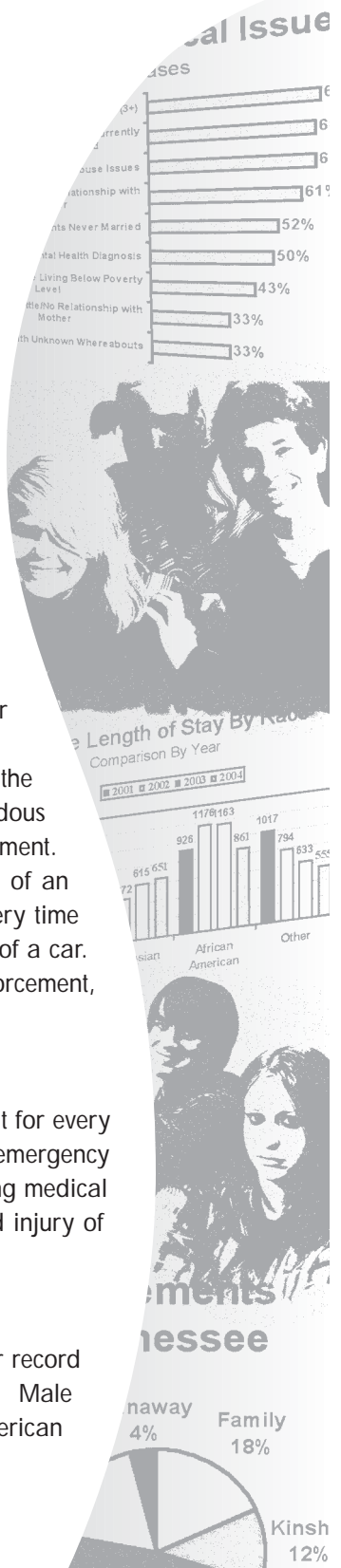


While tragic, deaths from injuries are a small part of the picture. Experts estimate that for every injury death, there are 41 injury hospitalizations and 1,100 cases of injuries treated in emergency departments.¹ Unintentional childhood injuries cost billions of dollars every year (including medical expenses, future work lost, and lost quality of life), with an estimated cost per childhood injury of \$17,000.²

NATIONAL DATA



Nationally, mortality rates peaked in the early 1990’s but have since fallen to or near record lows for all adolescents. However, significant disparities persist in mortality rates. Male adolescents continue to die at more than twice the rate of female adolescents, and American Indian and African-American males continue to die at the highest rates.³





Healthy People 2010 Objective 16-03:

Reduce deaths of adolescents and young adults,
rate per 100,000

Ages	U.S.	TN	2010 Objective
10-14	22.1	23.8	16.8
15-19	70.6	73.2	39.8
20-24	95.3	122.8	49.0

Source: Tennessee Department of Health,
Office of Policy, Planning and Assessment, 2003
National Vital Statistics System, 1998

Healthy People 2010 Progress

Tennessee has significant challenges to address in order to meet Healthy People 2010 goals for reducing the mortality rate among adolescents and young adults. The greatest gap in meeting Healthy People 2010 goals is with the 20-24 year old age group.

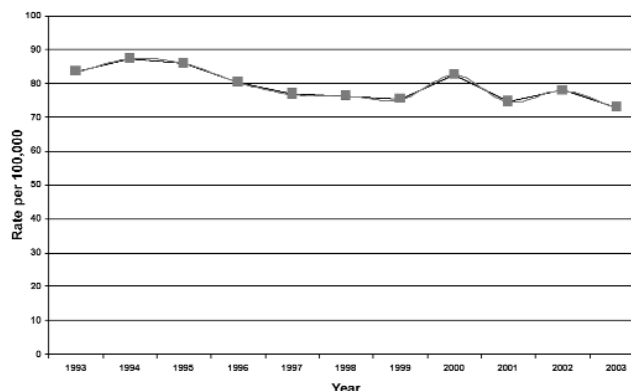
HEALTH DISPARITIES

- White males ages 10-24 are more likely to die from unintentional injuries, the vast majority of which are motor vehicle crashes.
- African-American males ages 10-24 are almost twice as likely to die by homicide as from an unintentional injury.

The overall mortality rate for adolescents and young adults ages 10-24 has been gradually declining since 1994 (See Figure 1).

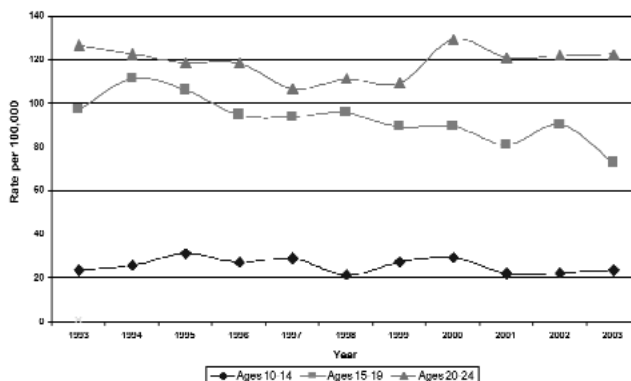
Unintentional injury remains the overwhelming leading cause of death for youth and young adults ages 10 to 24 years. In 2003, over 51% of all deaths for young people ages 10-24 were attributed to unintentional injuries. The next highest causes of death were homicide (13%) and suicide (9%).⁴ The number of adolescent deaths due to injuries has increased over the last decade. From 1999-2003 there were 2,285 unintentional injury deaths (See Table 1 and Figure 3).

Figure 1
Mortality Rate, Tennessee, Deaths Per
100,000, 1993-2003, Ages 10-24



Source: Tennessee Department of Health, Office of Policy,
Planning & Assessment, Division of Health Statistics

Figure 2
Mortality Rate, Tennessee, Deaths
Per 100,000, 1993-2003,
Ages 10-14 and 20-24



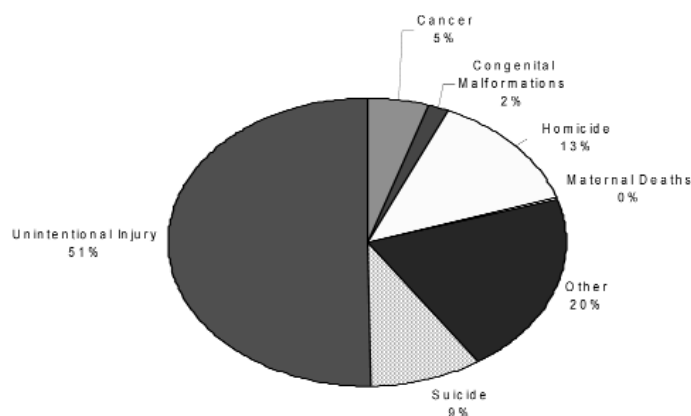
Source: Tennessee Department of Health, Office of Policy,
Planning & Assessment, Division of Health Statistics

TABLE 1**RESIDENT DEATHS AGES 10-24, TENNESSEE**

Category	1999	2000	2001	2002	2003	5 Year Total	5 Year Percents
All Causes	879	973	886	935	880	4553	100.0%
Cancer	57	41	37	41	51	227	5.0%
Congenital Malformations	12	14	16	19	16	77	1.7%
Homicide	110	137	114	130	112	603	13.2%
Maternal Deaths	5	3	6	3	2	19	0.4%
Other	186	181	169	189	190	915	20.1%
Suicide	80	100	87	74	86	427	9.4%
Unintentional Injury	429	497	457	479	423	2285	50.2%

Source: Tennessee Department of Health, Office of Policy, Planning & Assessment, Division of Health Statistics

Figure 3
Total Resident Mortality for Adolescents ages 10-24,
1999-2003, Tennessee



Source: Tennessee Department of Health, Office of Policy, Planning & Assessment, Division of Health Statistics

Age Matters

As with all of the behaviors discussed in this report, the data differ when younger adolescents are compared with older adolescents. Older teens and young adults (ages 15-24) are more likely to be involved in a fatal injury than younger teens. The primary reason for the difference in unintentional injury deaths between younger and older teens is the fact that older teens and young adults are driving.

Race Matters

White males ages 10-24 are more likely to die from

unintentional injuries, the vast majority of which are motor vehicle crashes. African-American males ages 10-24 are almost twice as likely to die by homicide as from an unintentional injury.⁵

MOTOR VEHICLE CRASHES

PREVENTION PAYS



Motor vehicle crashes are expensive. In 1999, the economic cost of police-reported crashes (both fatal and nonfatal) involving drivers aged 15 to 20 was \$32 billion.⁶

Healthy People 2010: Objective 15-15:

Reduce deaths caused by motor vehicle crashes in adolescents ages 15-24, rate per 100,000.

Ages	U.S.	TN	2010 Objective
15-24	26.2	42	[1]

[1] 2010 target not provided for adolescents/young adults age group

Source: National Vital Statistics System, 1999
Tennessee Department of Health, 2001

Healthy People 2010 Progress

The Healthy People 2010 target goal has not been established. Tennessee rates for motor vehicle fatalities for all teens and young adults, ages 10 to 24, stayed about the same from 1999-2002. However, preliminary population data for 2003 show a significant increase from 1,618 fatalities in 2002 to 2,365 fatalities in 2003. Since motor vehicle crashes are the leading cause of death among 15-24 year olds, significant attention should be focused on reducing Tennessee's rate.

HEALTH DISPARITIES

- Sixty percent of the young people who died from motor vehicle crashes were white males, followed by 26% white females, 9% African-American males, and 4% African-American females.

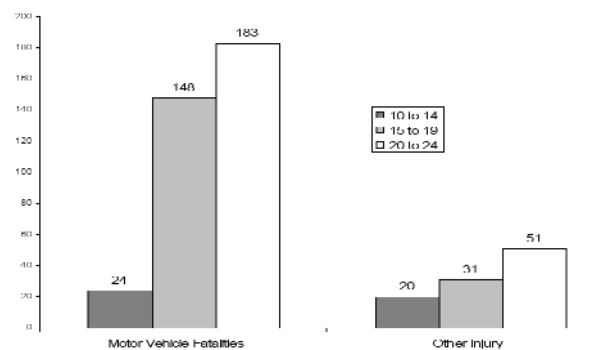
For adolescents and young adults ages 10 to 24, both nationally and in Tennessee, over three-quarters of unintentional injury deaths are motor vehicle-related. On the basis of miles driven, teenagers in this age group are involved in three times as many fatal crashes as are all drivers.⁷ Implementing strategies during adolescence to prevent motor vehicle crashes is critical to adult health and well being because young adults experience many of the same behavioral issues as adolescents.

In Tennessee, the Motor Vehicle Crash (MVC) death rate in 2001, for 15 to 19 year olds was 37.5/100,000 and substantially increased to 47.4/100,000 in the 20 to 24 age group. In 2001, MVC make up 41.5% of all deaths in the two age groups combined.⁸

Tennessee adolescent and young adult (ages 10-24) motor vehicle death rates are much higher than those of the nation as a whole. Tennessee rates are 30 per 100,000 while U.S. rates are 19 per 100,000 population.

- 1,419 youth ages 10-24 died in a motor vehicle accident during 1999-2002. Of these fatalities, 7% were ages 10-14, 45% were ages 15-19 and 48% were ages 20-24.
- Tennessee rates for motor vehicle fatalities for all teens and young adults, ages 10 to 24, stayed about the same from 1999-2002.⁹

Figure 4
Tennessee Motor Vehicle Fatalities
Compared to Other Unintentional Injury,
Ages 10-24, 2002



Source: Tennessee Department of Health, Office of Policy, Planning & Assessment

MOTOR VEHICLE SAFETY

Why is Driving so Dangerous?

Teen driving is relatively deadly due to a combination of inexperience, overconfidence, risk-taking behavior and greater risk exposure.

- Teens have less experience behind the wheel than older drivers.
- Teens are less likely to wear seatbelts than older drivers.
- Teens are more likely to drive at night, with other teens as passengers, thus increasing the risks of distraction and the influence of peer pressure.¹⁰

The Youth Risk Behavior Survey (YRBS) provides an indication of risks that teens take with regard to motor vehicles. Teens report on drinking and driving, seatbelt use, and riding in cars with drivers who have been drinking. Tennessee data generally mirror national data.

SEAT BELTS

Healthy People 2010: Objective 15-19:

Increase the use of safety belts in high school students

	1993	1999	2003	2010 Obj.
TN Students	69.1%	78.3%	85.6%	92%

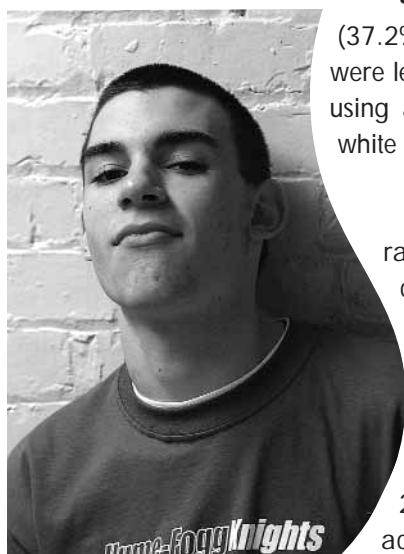
Source: Tennessee YRBS Survey, 1993, 1999, 2003

Healthy People 2010 Progress

Tennessee high school students report a marked improvement in increasing the use of safety belts from 1993 to 2003. However, educational efforts need to continue so that the Healthy People 2010 goal can be achieved.

HEALTH DISPARITIES

- Males (19.8%) are more likely to report rare or no use of seat belts than are females (9.6%).
- African-American (37.2%) high school students were less likely to report always using a seat belt compared to white students (45%).



Investigations into the rate of use of seat belts are crucial to understanding the threat of motor vehicle fatalities to the adolescent population. Nationally, 62% of adolescents, ages 16 to 24 involved in fatal accidents, were not

wearing seat belts.¹¹ In response to 2003 YRBS survey questions pertaining to students riding in a car, driven by someone else;

- 14.3% of Tennessee's high school students report never or rarely wearing a seat belt.
- Males (19.8%) are more likely to report rare or no use of seat belts than are females (9.6%).
- The use of seat belts decreases with an increase in age, from 15 to 18.
- In addition, 37.2% of African-American high school students reported always using a seat belt compared to 45% of white students.¹²

DRINKING AND DRIVING

Healthy People 2010 Objective 26-01(a):

Reduce deaths, in ages 15-24, caused by alcohol and drug related vehicle crashes, rate per 100,000.

Ages	U.S.	TN	2010 Objective
15-24	13.5	6.7	[1]

Source: Fatality Analysis Reporting System (1998), Tennessee Department of Safety (2001)

[1] 2010 target not provided for adolescent age group.

Healthy People 2010 Progress

Healthy People 2010 target goals have not been set for reducing deaths caused by alcohol and drug related vehicle crashes. However, since the leading cause of death among young people ages 15-24 results from motor vehicle accidents, it is crucial to address drinking and driving issues.

HEALTH DISPARITIES

- No data were identified to determine health disparities among young people ages 15-24 who died as a result of alcohol and drug related vehicle crashes.

Any impairment of the driver places the adolescent at high risk. Alcohol related motor vehicle crashes are a real and serious threat to Tennessee's adolescent population.¹³ The threat of alcohol related motor vehicle

fatalities becomes more severe with increases in age of the adolescent population. In 2001, alcohol related fatalities made up about 40% of all motor vehicle fatalities for Tennessee adolescents twenty years of age or older. There was about a ten percent decrease in the percentage from 2000, down from 48% to 38% in 2001. Unfortunately, the Department of Safety was unable to obtain test results from about 30% of the cases, so there is most likely serious under reporting.¹⁴ There were 6,648 arrests for *Driving Under the Influence* among adolescents ages 24 and younger, in 2002.¹⁵

High School Students Who Ride With Drivers Who Have Been Drinking

Healthy People 2010 Objective 26-06:

Reduce the proportion of adolescents who report that they rode, during the previous 30 days with a driver who had been drinking alcohol, by percent.

	1993	1999	2003	2010 Obj.
TN				
Students	35.9%	32%	26.6%	30%

Source: Tennessee YRBS Survey, 1993, 1999, 2003

Healthy People 2010 Progress

Tennessee has met the Healthy People 2010 goal for number of high school students riding with a person who had been drinking. However, prevention efforts should continue in order to maintain the downward trend.

HEALTH DISPARITIES

- White high school students (27.3%) are more likely than African-American (24%) high school students to have ridden in a car driven by someone who had been drinking.
- Males (25.9%) and females (27.4%) equally chose to ride with a person who had been drinking.
- African-American females (23.6%) are the least likely to have ridden in a car with someone who had been drinking.

According to the 2003 Tennessee YRBS, 26.6% of Tennessee's high school students reported riding in a car

operated by someone who had been drinking compared to 30.2% nationally.¹⁶

Other important data show that 11.2% of high school students who responded to the 2003 Tennessee YRBS survey indicated that they had driven a car in the past 30 days while they had been drinking. Tennessee's rate is lower than the national average of 12.1%. Many more males (14.6%) reported driving a car under the influence than females (7.8%). Fifteen year old students were almost a third less likely than 18 year olds to report drinking and driving. Students in 9th grade were almost half as likely as those in the 12th grade to report drinking and driving. White males and females were almost twice as likely as their African-American counterparts to have driven while drinking.

Unintentional Firearm Injuries

In Tennessee, during the period 1999 to 2002, there were 714 firearm-related fatalities to young people ages 10 - 24. Eighty-eight percent of those fatalities occurred among males, and the weapon used was usually a handgun. Most adolescent and young adult firearm fatalities can be described as intentional (92%). However, some are not. In Tennessee, about 6% or 45 actual firearm fatalities were unintentional. The number of unintentional firearm deaths doubled from 2001 to 2002.¹⁷

Sports and Recreation Injuries

Young athletes are not small adults. Adolescents may recover from injuries quicker than adults, but their bones, muscles, tendons and ligaments are still growing, which makes them more susceptible to injury. Sports injuries include broken bones, soft tissue damage (sprains, strains and tendonitis), growth plate injuries, dehydration, overheating (cramps, exhaustion, heat stroke, sunburn), repetitive motion injuries, internal



injuries (bruised or damaged organs), back injuries, and head injuries.

Each year, U.S. health care providers treat more than 3.5 million sports-related injuries in children under age 15.¹⁸ Knees and ankles are the most common injury sites but other injury sites, such as head and neck, may have more severe implications. For example, 20% of high school football players will suffer a head injury (i.e., concussion) at some point in their career, and those who have had a head injury are at two to four times greater risk of having another concussion.¹⁹

The American Academy of Pediatrics, the Centers for Disease Control and Prevention (CDC), the U.S. Consumer Product Safety Commission and other sports and health organizations recommend the use of appropriate and properly fitted safety gear, including helmets, for bicyclists, all terrain vehicle drivers and riders, scooter riders, motorcyclists, roller-bladers, skateboarders, equestrians, and football, lacrosse and baseball players, among others.²⁰

BEST PRACTICES FOR PREVENTION

Best practices are those strategies, activities or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying a risky/undesired health behavior or conversely, supporting and encouraging a healthy/desired behavior.

Parents

Parents have the initial role in injury prevention. They are the ones providing the transportation and the financial and emotional support for sports and recreational activities. They are the ones handing over the car or boat keys and paying for the insurance. They

are the first adults in an adolescent's life providing role modeling, and setting clear boundaries, with appropriate consequences, related to alcohol and drug use, curfews, behavior and rules of the road.

Sports and Recreation

- Enroll youth in organized sports through schools, community clubs, and recreation areas where there are adults who are certified athletic trainers (trained in the prevention, recognition and immediate care of athletic injuries).
- Make sure youth use the proper protective gear for a particular sport or recreational activity and make sure it is properly fitted.
- Ask the coach to provide warm-up exercises, such as stretching and light jogging, to help minimize the chance of muscle strain or other soft tissue injury during sports, and cooling down exercises to loosen the body's muscles that have tightened during exercise.
- Make sure coaches and staff are diligent about the necessity of sunscreen, a hat or sunglasses (where possible) to increase protection against the sun, and proper hydration techniques.
- Make sure coaches and staff discuss proper nutrition and strength-building techniques with young athletes.

Driving

- Make sure your teen does not get a driver's license until you are satisfied that he or she can drive in varied terrains and in various weather conditions. The same goes for driving a boat, all-terrain vehicle, motorcycle, or truck.
- Be a good role model: buckle up and do not drink and drive; insist that front and rear seat passengers "buckle up".

Firearms

- If your teen handles a firearm, make sure he or she has been properly trained in the proper use and storage of the firearm and ammunition.
- Install trigger locks and load indicators.
- Keep firearms and ammunition in secure storage.
- Remove firearms from the house if you have a depressed teen.



Safety

- Have your teen take a basic first aid course.
- Be a good role model: do warm-up and cool down exercises; do not drink while boating; wear a helmet and protective gear when on a bike, motorcycle, or when roller-blading; store firearms safely; have a fire safety plan for your house; control personal use of fireworks.²¹

Schools

According to experts at the National Center for Injury Prevention and Control, schools have a responsibility to prevent injuries from occurring on school property and at school-sponsored events. In addition, schools can teach students the skills needed to promote safety and to prevent unintentional injuries, violence and suicide while at home, at work, at play, in their communities, and throughout their lives.²² Schools have a variety of opportunities to make recreation injury prevention information available to parents, students and athletic staff. It can be delivered in the context of a comprehensive health education curriculum; such as on the playing fields, through after-school activities, and in educational materials for parents.

Schools can ensure that:

- Coaches, referees, parents and students understand grades of concussions and follow “return to play” rules;
- Young athletes know and follow safe sports techniques in warm-up, play and cool-down periods; nutrition and hydration; and risk avoidance;
- Athletic equipment is safety-oriented with attention paid to maintenance and appropriateness of playing surfaces;
- School personnel participate in staff development opportunities to gain knowledge, skills and confidence to promote safety and prevent unintentional injuries;
- Requirements for pre-season physical examination and for appropriate protective equipment during sports are enforced; and
- Appropriate medical coverage is provided at school-sponsored sporting events.²³

Communities

To change behaviors that cause injuries, communities can integrate strategies into the community and tailor them to meet their unique safety needs and opportunities for injury prevention. Strategies can include increasing public awareness through education or message marketing efforts, enhancing regulation and enforcement efforts, requiring parent involvement or creating safer environments. It is important to involve the relevant stakeholders in the planning and implementation process to increase their commitment and involvement in carrying out solutions.²⁴



Graduated Drivers' License (GDL) programs are a clear example of an injury prevention strategy established by policy. GDL programs restrict when adolescents can obtain a license and the conditions under which they can drive. Teens have to “earn” full driving privileges. Tennessee's GDL law went into effect on July 1, 2001. The law focuses on many of the factors that lead to motor vehicle injuries in adolescents.

- A first-time driver under age 18 must have a learner's permit for six months before he or she can apply for an intermediate license. Driving is prohibited from the hours of 10 p.m. to 6 a.m. Permit holders must have a licensed driver age 21 or older in the vehicle with them, and seatbelt use is mandatory for everyone in the vehicle under the age of 18.
- A teen must be 16 and have had a learner's permit for six months before he or she can apply for an intermediate license.

- Applicants applying for an intermediate license must present certification that he/she has a minimum of 50 hours of behind-the-wheel driving experience, including a minimum of 10 hours of driving at night.
- Those with an intermediate license can only have one other passenger in the vehicle unless one or more of the passengers is age 21 or older and has a valid, unrestricted license or the passengers are young people who reside with the driver and going to and from school and the driver has written permission from their parent or guardian to transport their siblings. Intermediate license holders are prohibited from driving between the hours of 11 p.m. and 6 a.m. unless they are accompanied by a parent or guardian or their designee who is 21 or older; driving to and from a school activity or event and have written permission from parent or guardian to do this; driving to and from work and have written permission; and driving to or from hunting or fishing between 4 a.m. and 6 a.m. and have a valid hunting or fishing license in their possession.
- To obtain a license, a teen must hold their intermediate restricted license for a minimum of one year and then apply for an intermediate unrestricted license.
- At age 18, a driver can apply for a regular unrestricted license without the word "intermediate" printed on it.²⁵

What Could Tennessee Do to Improve Motor Vehicle Safety for Adolescents?

The U.S. Department of Transportation's Community Guide to Preventive Services, Motor Vehicle Occupant Protection strongly recommends.²⁶

- Primary enforcement and enhanced, consistent enforcement of safety belt-use laws and alcohol/drug-impaired driving laws²⁷ (wearing seatbelts reduces the risk of a fatality by 45% and reduces the risk of a moderate to critical injury by half.²⁸
- Maximum .08 BAC for adult drivers.²⁹
- Sobriety checkpoints (e.g., on prom nights.)³⁰
- Hospitality employee training so that these employees can recognize underage or impaired drinkers.

Other states are exploring:

- Extending the length of time required for a learner's permit (e.g., North Carolina requires 365 days)
- Restricting the number of teen passengers³¹
- Emphasizing school prevention programs, addressing alcohol use on college campuses
- Targeting judges, prosecutors and law enforcement officers for special training on youth alcohol and substance use.³²

Zero Tolerance Law

Laws like Tennessee's that make it illegal for persons under 21 to drive with a positive BAC have reduced impaired-driving fatalities by 4% on average. Per licensed youth driver, this law costs approximately \$30 and yields net savings of \$600. Medical care cost savings alone exceed the intervention cost. The primary cost is the value of mobility lost by youth who are forced to reduce their drinking or driving.³³

TENNESSEE INJURY PREVENTION PROGRAMS

Tennessee Department of Transportation Programs

Click It or Ticket Program

Sponsored by the Governor's Highway Safety Office, Tennessee's law enforcement agencies and



public health officials, Click It or Ticket aims at reducing serious injuries and fatalities on Tennessee's roadways by reminding everyone to buckle up. The Click It or Ticket enforcement blitz is scheduled for periods surrounding Memorial Day, Independence Day and Labor Day. Drivers and passengers are subject to the law when in a moving vehicle. Drivers are responsible for themselves and for all children less than age 18 in the front or back seat. Front seat passengers ages 18 and older are responsible for themselves and would get the ticket rather than the driver.

Law Enforcement Liaisons (LELs)

Tennessee presently employs three Law Enforcement Liaisons (LELs) one each regionally based in West, Middle and East Tennessee. The three LELs serve as a link to promote highway safety campaigns with law enforcement agencies for the Governor's Highway Safety Office (GHSO) and the Tennessee Association of Chiefs of Police (TACP.) The LELs provide technical assistance and coordinate and network with law enforcement agencies, associations and personnel statewide. While serving the public, LELs promote occupant protection through education, media, and outreach. Each is a certified Child Passenger Safety (CPS) Technician and works with area law enforcement agencies and other appropriate partners to plan and conduct child passenger safety clinics and inspections.

Tennessee Department of Health Program Safety and Injury Control Program

The function of the Safety and Injury Control Program is to develop and implement initiatives and services promoting injury prevention and safety. These endeavors include data collection and dissemination, providing accessibility to related resources and materials, technical assistance to county health departments and local coalitions, collaboration with public and private entities, and coordinating development and evaluation of specific targeted programs. These efforts are applied in order to promote good health safety for a high quality of life for Tennessee residents.

End Notes

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